TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
INSTITUTE FOR ATHLETIC MEDICINE

MFDR Tracking Number
M4-16-1344-01

MFDR Date Received
January 20, 2016

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per review of the EOB we received from Texas Mutual, this was denied stating unauthorized. However, authorization was requested on 6/12/2015 and approved on 6/17/2015. Since authorization was requested prior to this date of service, this bill should be included in the authorization that was given for 12 visits starting 6/12/2015."

Amount in Dispute: $203.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor received preauthorization to provide physical therapy three times a week for four weeks as stated by the preauthorization letter of 6/16/15. (Attachment) The same letter also identified the date range of this authorization as 6/16/15 – 7/24/15. However, the requestor provided therapy starting 6/15/15. As a result Texas Mutual declined to issue payment for the non-authorized 6/15/15 physical therapy. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2015	97110, 97112 and 97140	$203.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W3 & 350 – This bill has been identified as a request for reconsideration or appeal.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-197 – Precertification/authorization/notification absent.
   - 891 – No additional payment after reconsideration.
   - 930 – Pre-Authorization required, reimbursement denied.

Issues

1. Did the requestor obtain preauthorization for the disputed date of service, June 15, 2015?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97110, 97112, and 97140 rendered on June 15, 2015. The insurance carrier denied/reduced the disputed services with reduction codes "930 – Pre-Authorization required, reimbursement denied and CAC-197 – Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning; (iii) Orthotics/Prosthetics Management; (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code..."

   Review of the preauthorization letter dated, June 16, 2015 documents the following:

Requested Service Description	Certified Quantity	Start/End Date
Occupational therapy 3 x wk x 4 wks	12	June 16, 2015 – July 24, 2015

   The requestor asserts, "Since authorization was requested prior to this date of service, this bill should be included in the authorization that was given for 12 visits starting 6/12/2015."

   The Division finds that although the requestor obtained preauthorization for occupational therapy, the authorization was obtained after this disputed service was rendered. As a result, the Division finds that the requestor submitted insufficient documentation to support that preauthorization prior to providing the dispute services was obtained for date of service June 15, 2015. Therefore, reimbursement cannot be recommended.
2. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that CPT Codes 97110, 97112 and 97140 rendered on June 15, 2015 were included in the preauthorization letter dated June 16, 2015. As a result, reimbursement for the disputed services cannot be recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 5, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.